No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF LAWRENCE J. FRIEDERS AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

Lawrence J Frieders, from Aurora, IL, works with people in a persistent vegetative state. He has seen enough "spontaneous" cures, called by some "miraculous" cures to wish to caution the Court against finding a US Constitutional Right to starve and therefore kill certain patients based on the theory they are "hopeless" cases. He fears the logic of any general principle.

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SUMMARY OF ARGUMENT

Nancy Cruzan is not dead. The purpose of cutting off her nutrition and hydration is not to save her the burden of receiving nutrition and hydration because there is no evidence these are a burden. The purpose is to kill her via starvation and thirst. What logically follows a reversal? The Court will have elevated to a US Constitutional Right what has been condemned by all Christians, killing. What must logically follow is analyzed. Reversal will probably lead to ethical and moral disaster because of the radical general principles a reversal would legitimize. Dr Laurance Foye testified before a US Senate Committee. Those relevant parts of his argument are abstracted herein to show adverse practical results outweighing any good results.

Respect for life has been traditional in human society. It is based on recognition of human life as a basic good. Life is basic to any other good a human may have or acquire. Truth demands that one respect life as such a good. In our Judeo-Christian culture, this has carried with it several demands. It has traditionally demanded that no one take innocent human life. This included not only the life of other innocent people but that of the person himself or herself. Suicide has been considered as much a violation of respect for life as homicide.

Euthanasia

It has also been recognized that taking a human life by omission is just as wrong as taking it by commission.

Thus no distinction has been made between, for example, intentionally starving a person and stabbing him to death. Even if this is done with a good intention, *e.g.* out of mercy, it has been considered wrong. So what is called euthanasia has always been condemned in our society, and this is true of voluntary as well as involuntary euthanasia. The only difference between the two is that voluntary euthanasia would constitute suicide as well as homicide.

Duty to Preserve Life

Respect for life has also had another dimension. A positive duty to preserve the life has been part of the tradition. This is a duty which runs through the whole spectrum of human activity. It affects what one eats, drinks, wears, the kind of work he does, and the kind of recreation he takes,

whenever it involves some risk or danger to life. Again, it affects what he does as well as what he does not do. A person can show his lack of respect for life by omission as well as by commission.

From what has been stated above, it should be clear that respect for life demands that what the person does or does not do never fall into the category of suicide or homicide. This can happen in two ways: (1) if death is the only immediate effect of some act or omission, (2) if death is intended either as a means or an end.

If death is the only immediate effect of the act or omission, it must obviously be intended and, therefore, must constitute suicide or homicide. While this is a possibility, it may happen only rarely, since it does not often happen that an act has only one immediate ef-

fect. The more usual case would be one in which, although the act may have other effects, death is intended either as a means or an end.

Granted that what is done does not fall into either of these categories, it has generally been admitted that one does not have to do everything possible to preserve life. In other words, there are limits to what the person must do or not do to fulfill this duty. Thus, one does not have to rule out all danger or risk in the work he does, or even in the recreation he takes. Nor does one have to take all treatment necessary to preserve or prolong his life.

Principle of Double Effect. How does one decide, in these cases, what is of obligation and what is optional? In technical language, we are dealing here with what is called the principle of dou-

ble effect. In other words, we are dealing with an act which has a bad effect, and we are asking about the morality of such an act or omission. We have already pointed out that respect for life does not demand that we avoid any act or omission that carries with it risk or danger to life (bad effect). We have also pointed out that it would not be permitted to engage in such activity with the intention of bringing on death. But what if the act or omission is placed for some other reason? How would one determine its morality?

Besides the requirements already mentioned regarding intention, this principle requires that the reason for placing the act or for the omission be sufficient to justify the evil effect. We can illustrate with the example of the space shuttle. Those who have gone up in it

were certainly aware of the risk to life, yet none of them went up with the intention of ending their lives. They went up because of the good this program gave hopes of accomplishing. It was generally felt that this was sufficient to warrant the risk to life involved. I think it would be generally agreed that, presuming that known risk was reduced to a minimum, the conditions of the principle of double effect were verified and going up was morally permissible.

Nutrition and Hydration

Our concern here is not with any or every act or omission that carries with it risk to life, but with a specific act. We are concerned with foregoing eating and drinking with resulting risk to life or even certain death. The question is whether and under what circumstances one

may withhold/withdraw nutrition and hydration from a patient.

This question has arisen in the context of the discussion that has taken place over the past ten or more years regarding the obligation to take medical treatment. It is generally agreed that the obligation to take the medical treatment, like the obligation to preserve life, has its limitations. The question now being asked is whether the duty to eat and drink has the same limits as medical treatment, or is there a difference?

There is clearly a difference between eating and drinking, and medical treatment. Medical treatment is aimed at curing a disease. Eating and drinking are not aimed at curing disease, but at sustaining life. Medical treatment is therapeutic; eating and drinking are not basically therapeutic. So there is no

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doubt that eating and drinking, and medical treatment are two different procedures.

But this does not answer the question which is whether there is a difference in the obligation to eat and drink and the obligation to take medical treatment. The pertinent question is whether the differences pointed out above are morally relevant; that is, whether they would affect the moral obligation. Would they, for instance, make the obligation to take food and drink an absolute one, whereas the obligation to take medical treatment would remain limited?

Unique Obligation?

There is the contention that there is no difference between these obligation. As already pointed out, there is one duty to preserve life and that duty affects everything we do in so far as it

involves danger or risk to life. We are not speaking of two distinct duties, one to eat and drink, the other to take medical treatment. There is only one duty, the duty to preserve life, and this duty must be taken into consideration in anything a person does which involves risk or danger to life. Since this duty has its limitations, these limitations as well as the duty itself affect everything we do. As pointed out, it would obviously not be permissible to forego eating and drinking to bring on death. But if some other reason were present, it could be justified. One would admit, for instance, that if there were only enough food and drink for one person, a grandparent could forego eating in favor of a grandchild, just as he could forego medical treatment. One cannot say that it would be intrinsically evil to forego

eating and drinking even to the point of death. If the omission can be justified according to the principle of double effect, it would be morally permissible. We are not asking here whether foregoing food to save the life of another can be justified, but whether other reasons can be offered, and if so, what reasons.

The moral norm that has been generally accepted regarding the duty to preserve life is that, if what is omitted is useless in prolonging life or excessively burdensome and is omitted for this reason, the omission would be morally permissible.[1]

Useless Means. If what is omitted is useless, that is, if it would not pro-

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1 Such a means has been traditionally called an "extraordinary" means. A means which was useful and not burdensome was considered "ordinary" means, and obligatory. This distinction means different things to different people, and so has gone out of favor.

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long life perceptibly, there would obviously be no obligation to use it. If morality is to be reasonable, one cannot impose an obligation on a person to do something useless. This would make no sense. Today, however, this principle is not being properly used. It is used to free one of an obligation to use means if it would not cure some disease. Thus, if a particular disease is irreversible, some would want to argue that it would be permissible to withdraw even nutrition and hydration, since they could not reverse the disease. But this ignores the whole meaning of the question, which is about the duty to prolong life, not the duty to cure disease. Obviously, if one were talking about the latter, one could not directly impose an obligation to eat and drink – since it would not cure the disease. In fact, one could never impose

an obligation to eat and drink on this score, since eating and drinking as such are not therapy.

So it makes no sense to relate the obligation of nutrition and hydration to whether the disease can be reversed or not. The only legitimate reason for withdrawing it would be that it would not prolong life perceptibly, so that the patient would die within a short space of time whether he ate or not.

Burdensom Means. What if a means is excessively burdensome? In that event, a patient would be permitted to forego the means. This is permissible because a humane morality does not place on a patient an obligation that would be too difficult for him to bear or fulfill. No distinction can be made here between treatment and feeding. For a particular patient, eating can be just as difficult as treat-

ment. It would not be reasonable to demand that such a patient accept one and not the other. Indeed foregoing either would be wrong, as pointed out above, if death was the only immediate effect, or it was intended.

The assumption is that neither is or has to be the case. Death is not the only immediate effect. If a means (treatment or feeding) is excessively burdensome, refusing treatment has another immediate effect – avoiding the burden of the treatment (or feeding). If this is what the patient intends, omitting eating and drinking could be justified as a legitimate application of the principle of double effect. He is not doing something wrong in itself, he does not intend the evil effect, and he avoids the burden which eating involves.

When theologians speak of a means to preserve life that is excessively burdensome, they usually break it down into hardship, pain, cost or danger. If the use of some means involved what would be judged excessive in any of these areas, a patient would not be obliged to take it. It would be optional.

Burden to the Family. Ethicists are obviously speaking of burden to the patient. If the burden is to the patient, he is relieved of any obligation to use the means. But the option is not limited to burden to the patient, a patient would be free to omit a means to preserve life even if he did so to remove a burden from the family. If a patient had no insurance, and he wanted to spare the family the astronomical (and hence too burdensome) costs some treatments involve today, it would be permissible for him to

do so. In fact, he might be more concerned about the burden to his family than about the burden to himself.

Burden to Society. In today's society, the burden of cost is usually shifted to some insurance company, or to society if the patient is on medicare or medicaid. So the patient cannot often omit treatment because of the burden of cost to himself. Would it be permissible for him to omit treatment because of the cost to the insurance company, or to society? This is certainly a possibility. Although it could happen, it would be difficult to make any such presumption in the case of an incompetent patient.

Scarce Facilities

What about society itself? Could it terminate treatment even against the wishes of a patient? Society has the right and duty to distribute its own

funds. Since it never has enough funds to cover all the needs of a community, it must set limits. It would be permissible for society then to limit the funds given to health care both in general and in particular cases – as long as it observes distributive justice. But even in a situation where it might legitimately limit funds, it could not legitimately stop treatment itself. If the treatment could be provided from other funding, society could not stop it. The only situation in which society could stop treatment would be one in which treatment facilities themselves were scarce. There society could set limits.

Even in this situation, however, society would be bound by moral norms. It would be no more permissible for society to intend the death of a patient than it would for the patient himself. So while

society may limit treatment, it may not do so with the intention of ending the life of a patient. Society also has the obligation of not discriminating against patients.

The fact is that society has not set such limits, so the above discussion is purely theoretical. Scarce facilities have not even been a factor in the cases that have come into the courts. Indeed on a case by case basis, it would seem impossible to avoid discrimination.

Briefly, it is not permissible to forego means to preserve life with the intention of bringing on death, but it is permissible to forego such means would not appreciably preserve life or when, even if it would, it would be excessively burdensome.

Quality of Means v. Quality of Life

Today this whole discussion has entered into a new phase. In the past, as described above, the emphasis was on the means. Sometimes the distinction was made between ordinary and extraordinary means to clarify the obligation to preserve life. In the past five or ten years, a new emphasis has been added. Some are looking not only at the means but also at the patient. They would like to distinguish between ordinary and extraordinary patients, as well as ordinary and extraordinary means. The underlying reason is that they would like to make an allowance for extraordinary means. In other words, they would like to withhold or withdraw treatment on the basis of the quality life of the patient as well as the quality of means. Thus, if the quality of life of the patient was below a certain standard, they would argue that

the means of preserving life could be withheld or withdrawn even apart from any consideration of their burden or capability of prolonging life.

Superficially, it would seem that, if one could withhold means on the basis of the quality of the means, it could be done on the basis of the quality of the patient's life. Thus, if one could withhold means because they are useless or excessively burdensome, it would seem that one should be able to withhold them if the patient's life itself is useless or excessively burdensome. In general, advocates of this approach are usually much more demanding in dealing with quality of life than they are with quality of means. They would argue, for instance, that, if a person was in an irreversible coma or a persistent vegetative state, it would be permissible to withhold means to

preserve life, including food and hydration. They would not include other incapacitating handicaps. Similarly, they might argue that, if the patient's life was extremely burdensome, not just excessively burdensome, it would be permissible to withhold means to preserve life.

New Moral Category. What about the morality of this argument? As already indicated, it might look as though this was just another step in the same direction. This is part of the problem – the move may not be recognized for what it is. Actually, it represents a quantum leap from what is and has been considered acceptable. It is not in any way in continuity with past practice but involves a move into an entirely different category of moral act. For example, when one withholds or withdraws means to preserve life because it is too burdensome,

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his intention is to spare the patient the burden somehow involved in the use of the means. There is no intention of bringing on the death of the patient. Even if the patient lives (as in the Quinlan case), the goal is achieved. He or she is spared the burdensome means.

But, if one omits some necessary means because of the patient's low quality of life, the intention is to bring the life of the patient to an end. Presumably, the patient's condition cannot be reversed, so the only solution to the problem is the death of the patient.

What this means is that we are omitting treatment with the intention of bringing on death. In other words, we are violating our duty to respect life. As mentioned earlier, respect for life demands that we do nothing (and omit nothing) that involves danger or risk to

life with the intention of bringing on death. The fact that it is being done with a good intention, to end the patient's pain, does not change the basic nature of the act. It is euthanasia. This has been defined as an act or omission which by nature or by intention brings on the death of the patient out of mercy. Both the moral and the civil law have always abhorred euthanasia. Killing is killing whether it is done with a good intention or not.

Moral Sensitivity. Awareness of the magnitude of the step from quality of treatment to quality of life is crucial to moral sensitivity in this area. The introduction of moral evil into society can be and often is imperceptible, and one can easily be lulled into a false

sense of security if he underestimates what look like small steps. The astronaut who first stepped on to the moon said that it was just a small step for a man, but he and everyone else knew that it was a giant step for mankind. The same has to be said for the step into quality of life reasoning. It may look like a small step, but in reality it is a giant moral step. One is entering into an entirely different category of moral act – intentionally bringing on death. If one makes this move under the illusion that it is a small step and in continuity with the past, he will be blissfully, but also sadly, ignorant of the disastrous implications of what he is doing. He is leaping in the dark. What is even worse is the failure to realize that this leap will land him on a slippery slope, and with no breaking power.

It would be bad enough to limit this quality of life move to an extreme case of rare occurrence. For the reason given above, the truth is that there is no effective way of controlling it, or of drawing a legitimate line. In other words, there is no acceptable or manageable criterion that can be used to justify withdrawal of treatment in some cases and legitimately exclude it in others. Once the line between quality of treatment and quality of life is crossed, there is no effective way of drawing another line. Today, we are intentionally ending the life of a person in an irreversible coma or a persistent vegetative state. Tomorrow, it will be the person with Altzheimer's disease. The next day, any chronic mental patient will qualify. Then, or even before, incapacitating physical handicaps will be considered.

There is no way in which one can take the first step, or the second step and stop there. This threat is aggravated by the fact that the judgment in these cases is made mostly by third parties, with all the hazards this implies. Eventually we will find ourselves in a society in which only those with an optimal quality of life will be secure – the opposite to a democratic society in which all are considered equal.

That this is not all just fantasy is clear from a recent article in the *New England Journal of Medicine*. There the statement is made that it is ethically permissible to withhold nutrition administered by gastric tube from "severely and irreversibly demented patients," if

such patients reject food and water by mouth.[1]

Wishes of Patient

What if the patient had made a living will, or indicated in some other way that, if he or she is ever in an irreversible or incurable condition, he does not want treatment, even artificial feeding? It is quite true that the decision regarding treatment is up to the patient. But from a moral perspective, the patient is not at liberty to decline all and any treatment, especially nutrition and hydration. If a patient foregoes treatment that is not burdensome and will prolong life, he is going beyond his legitimate option and violating his duty to respect life. Even if a patient were to make

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[1] Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *The Physician's Responsibility Toward hopelessly Ill Patients,* 310 NEW ENGLAND JOURNAL OF MEDICINE., 955, 958-59 (1984).

such a request, those responsible for her could not condone it or freely cooperate with it. This, of course, puts the attending physician in a difficult position, at least from a legal perspective. What is clear is that a request by the patient will not justify the omission of treatment when this would be immoral.

Hopeless Case

Advocates of a quality of life approach to justify withdrawing means to preserve life will frequently give as their reason the fact that a particular case is hopeless. Hopelessness can mean many things. If it means that there is no hope of cure, it cannot be a valid reason for withdrawing the means to preserve life. Many diseases are incurable, e.g., diabetes, but [illegible] would suggest that one should [illegible] a diabetic insulin because the disease cannot be

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cured. So the fact that the condition cannot be cured is not in itself the reason for withdrawing treatment. When a case is called hopeless in the present context it seems to mean not only that the condition is not curable but that the quality of life of the patient is so low that it is useless to continue it. Again we are dealing with a quality of life reason in which the solution is the death of the patient.

Persistent Vegetative State. It is also argued that means to preserve life, including feeding, may be removed when the patient is in what is called a persistent vegetative state. Whether a human being who is still alive can be said to be in a persistent vegetative state can be seriously challenged. As long as a human soul is present, and this is the case until the patient is at least brain

dead, human life is present. It is not just vegetative life. Also, the only thing we are sure about in these cases is that the patient cannot communicate with the outside world. We are not at all sure that he or she cannot receive some communication from outside. Nor can we rule out some kind of interior life. To say that there is only vegetative life in a human being who is still alive goes beyond any evidence we have.

"Natural" Death

Some will want to argue that prolonging life by treatment or artificial feeding is putting off the natural time of death, and so cannot be obligatory. Before accepting this objection, which really proves more than the opposition would want, one would have to know the answer to the question: when is death natural? If we go back into the Old

Testament, we will come to a time when any kind of human intervention in disease was considered interfering with Divine Providence. It was the prophet Sirach who argued that God created the herbs and the drugs, just as he created food and drink, and endowed the doctor with knowledge to cure the sick, and so wanted us to use them just as we use his other gifts. So prolonging life by using these gifts is not interfering with Divine Providence but really cooperating with it.

No one today would argue that all therapy involves interference with nature or Divine Providence. But some even today seem to want to maintain that there are times, such as in the case of a person in a persistent vegetative state, when one should withdraw and let nature take its course. We have already pointed

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out that there are times when treatment is optional, but this is because the treatment is useless or excessively burdensome. We dc not judge it optional because, in a particular case, we think a judgment can be made that death is natural. There appears to be no way of making such a judgment except in the case where death is going to occur in a short time whether treatment is used or not. But in this case, the decisive factor is the uselessness of the means, not the judgment that death is "natural."

Intending Death or Letting Die. In the same vein, some will maintain that, in these cases, they are not intending death but letting death occur or letting nature take its course. There is certainly a clear distinction between intending, and permitting or allowing. If one looks at the situation superficially,

he might be tempted to conclude that, since the person is not taking any positive action to bring on death, he is merely permitting it to occur. As we have seen, however, an omission can be just as effective as an act in bringing on death comes from the original disease. He dies of starvation. But even if one omits some medical treatment, although the disease may ultimately account for the death of the patient, the omission of the treatment brings it about sooner, thus shortening the patient's life.

It is indeed true that an act or omission from which death results is not in itself immoral. The decisive factor is the intention. It is when this is done to end or shorten the life of the patient that it becomes immoral. Since this is what happens when some means to preserve life is deliberately not pro-

vided because of the quality of life of the patient, it is our contention that it constitutes intentional euthanasia by omission. One is not merely letting the patient die.

Prolonging the Dying Process

Sometimes withholding /withdrawing means to preserve life is justified by the claim that one is merely "prolonging the dying process." This claim can be valid in a situation where the patient is going to die within a short time whether the means is used or not, or where the means will not appreciably prolong the life of the patient. Unfortunately, the term "dying process" has been given a very vague and indefinite meaning in recent times. It has been defined, for instance, as a situation in which, if the means were not used, the patient would die in a short time. But if the means

were used, the patient might continue to "die" indefinitely. If this was applied to nutrition, all of us could be said to be in the dying process, since we would all die in a short time if we stopped eating. One must conclude that unless the term is carefully defined, it is too vague to be meaningful.

Reversing would Mean Euthanasia

Briefly, then, even if one does not place some positive act of violence but simply omits something necessary to preserve life, he can be guilty of euthanasia. It all depends on his intention. If his intention is to spare the patient a burdensome treatment, or one that is useless to preserve life, the omission can be justified. But if his intention is to bring on death, it is euthanasia. Since the latter intention is present

when nutrition and hydration are omitted for quality of life reasons, the failure to provide them has to be condemned as intentional euthanasia by omission.

WHY TREAT HOPELESS CASES?

Selected portions of testimony discussing hopeless cases [before 1972 US Senate subcommittee] of Laurance V. Foye, Jr. M.D., Director of Education Service, Veterans' Administration, formerly with the National Cancer Institute.

Dr. Foye. A number of complex problems are encompassed by the popular but obscure phrase, death with dignity. These include: the hopeless case, prolongation of suffering, active and passive euthanasia, the "right to die," and "living will."

Essentially, these are all medical problems relating directly to the

responsibilities and decisions of the physician in his relationship with his patient. Rational consideration of these questions is unfortunately and customarily confused by opinions based upon misconceptions and emotion.

A discussion of the "hopeless cases" will bring up most of the problems mentioned above.

We must not equate incurability with hopelessness. Diabetes, emphysema, practically all heart disease, baldness, and flat feet are incurable but rarely hopeless. The incurable cancer patient may live 3 months, or 3 years, or 30 years with his disease, possibly earning a living, raising a family, and enjoying life during this period. He may or may not require treatment along the way and he may or may not die of this disease.

These statements are generally true

of all incurable diseases. With cancer, as with other incurable diseases, there are spontaneous remissions, when the disease lies dormant, and even rare spontaneous cures.

Typically, in incurable diseases, the future course of the disease in a specific patient is not predictable except in a statistical sense. Thus, if 100 patients with similar disease, 20 die in 5 years, a specific patient may be said to have a 20 percent chance of dying in 5 years.

Therefore, while our prediction or "prognosis" in the individual case is based upon experiences with many different patients, usually treated differently by different doctors, the decision regarding euthanasia or "hopelessness" always relates to a specific patient whose course is not

specifically and accurately predictable.

Every physician can, as a result, describe a number of patients for whom he predicted a rapidly fatal outcome-saying, "I knew they were going to die" - and was wrong. The patient who was told by his doctor that he had 6 months to live but is alive years later is legendary.

Thus, since the practice of any form of euthanasia, active or passive, can only be justified by certainty of outcome, and we can't be certain for any specific patient, we dare not authorize or practice euthanasia.

If a physician withholds maximum effort from patients he considers hopelessly ill, he will unavoidably withhold maximum effort from an occasional patient who could have been saved. Patients will die because of the physician's decision not to treat

actively. This approach and concern cannot be fostered or condoned.

Typically, at this point in the discussion, the proponent of euthanasia then describes in detail a patient being kept alive "uselessly" with tubes and machines, and urges that the machines be turned off and the tubes removed "so the patient can die peacefully and with dignity."

Neither I nor anyone else knows how to decide when being alive becomes "useless"; I can only point out that "tubes and machines" are used because they save lives, relieve symptoms, and permit many patients to survive critical states of an illness.

Since it is usually a serious life-threatening problem that calls for these measures, they don't always work, and in spite of these efforts some

patients will die. One cannot then say, because such a patient dies, that these measures were a waste of time and shouldn't have been used, since when they are initiated it is not known in which patient they will be successful.

The statement made by noted clerics that the physician is not obligated to use "heroic or extraordinary" means in a "hopeless" case now becomes meaningless, since we can't be certain the case is hopeless, and it is precisely in such critical cases that "extraordinary" measures must be considered and may be effective.

Hippocrates was a safer guide when he said, "Extreme remedies are appropriate for extreme diseases."

It has also been pointed out that the extraordinary measures of today are the routine procedures of tomorrow.

The "living will", a document in which the patient permits and instructs his physician to let him die if his condition is hopeless, really solves nothing but does create problems of its own. The danger is that relatives, deciding for any number of reasons that active treatment should be stopped, will attempt, with or without legal support, to prevent the doctor from continuing his life-saving efforts, or that the doctor will find that the existence of such a document will be one "reason " to terminate his active treatment.

In any case, the complex and difficult decisions faced during the care of the critically, and possibly terminally, ill patient are in no way going to be simplified by " the living will," which would merely convert a possibly fatal outcome into a certainty

fatal one.

The "right to die" concept implies that, if our death is certain and immediate we have the "right" to make it even more immediate. The now obvious fallacy is the the patient or the doctor can know when death is certain. This is the "hopeless case" problem in human rights clothing except that we all are absolutely guaranteed "the right to die" at the moment of our conception.

We must never forget that on occasion patients, their families, and their physicians will conclude that a disease has reached the hopeless stage and death is imminent-and be wrong. If they can stop treatment on the basis of their hopelessness, the prophecy becomes self-fulfilling.

Whether the patient was going to die or not, their action ensures his death

and the physician's confidence in his ability to predict death is dangerously enhanced. We must keep in mind that all medical therapy, curative or palliative, only prolongs life and hopefully improves it's quality or what we call "health."

Finally, what many laymen fear is that doctor, in pointless attempt to postpone death, will keep them in agony for long periods of time-the prolongation of suffering problem. A number of studies have shown, and this corresponds to my experience, that the majority of critically or terminally ill patients do not have pain and that those who do can be controlled by the judicious use of pain-killing medicines.

It is essential that everybody understand that while a physician strives to cure a patient or to bring his incurable disease under control,

suffering can be prevented and severe pain need not occur.

We can now see that such approaches as legalized euthanasia and "the living will" are based upon the misconception that the point of hopelessness can be known with accuracy and that the physician may uselessly prolong suffering beyond that point unless forbidden by law or similarly excused from his obligation.

I fear that, unless people understand the false reasoning behind these concepts, the physician's hands may be tied in just those cases where his skill and modern technology can make the greatest contribution to the saving of lives and the control of disease.

Senator Church. Dr. Foye, I, by coincidence,just happen to be one of those legendary cases you mentioned in you testimony. I was once told I had only

6 month to live. It turned out later that the medical diagnosis had been wrong. I have a reason to appreciate your observation that it is extremely hard to be certain about the imminence of death and it is, I suppose, a statistical matter in that there are rare occasions when a seemingly hopeless case, even at the last stages, turns out not to be.

We base our legal system on an assumption that it is better to observe procedures that might let 10 guilty men go free rather than send one innocent man to the death chamber. Does it follow that we might adopt a similar attitude toward death in apparently terminal cases at the very last stage upon the theory that it is better than 100 people who are on the verge of death should be allowed to die as they wish, than to require treatment under the appropriate conditions and to

save the one that might prove saveable?

That is a philosophical question, I suppose, but it is one that we face in society all the time.

Dr. Foye. I think I would apply the "letting 10 guilty men go free rather than let one innocent man die" as being strongly in support of just what I have said.

Senator Church. But it is a statistical judgment, isn't it?

Dr. Foye. I think this is not a statistical judgement essentially, nor a legal one. It is the basis of medicine in this country and in many countries that the physician is responsible only to his patient and his responsibility is to do everything he can to cure his patient, to control his disease, to control his discomfort, and to make his life as pleasant as possible.

Senator Church. If as he approaches death he no longer wishes the kind of treatment because of his own suffering, perhaps, because he may be very old and recognizes that he has very little time to live anyway, he is prepared mentally and spiritually to accept this as the moment of death, do you think he has a right to say to his doctor, "Stop treating me"?

Dr. Foye. I think he has the right. That is absolutely essential in medical relationship. My experience however, with hundreds of incurable cancer patients over the period of 9 years is that I have never had one single patient refuse treatment or request that I let him die. I have never had it happen.

Every patient, of course, knew what was going on, knew what we could and what we couldn't do, knew what the risks were,

knew that he was a totally free agent to say at any point, " I am leaving," or " I don't want any more," or "Stop now." And this was made very clear repeatedly. Every patient understood that.

Senator Fong. Doctor, do you feel that a physician faced with a "living will" of the patient should follow it or shouldn't follow it?

Dr. Foye. I think I would have to know what the will said, I would have to have discussed this with the patient: "What was your intent," one would then have to, say, discuss with the patient what he wanted to do next about a given problem-just as if there were no "will."

Senator Fong. But if the patient is lucid, he could decide for himself, he could refuse treatment. But if he is not lucid, then what should the physician do?

Dr. Foye. Well, let's assume that you

are unconscious as the result of an automobile accident and that, if I can bring you to consciousness, you will end up with a stiff knee for the rest of your life. Now, if you read a "living will," it says that "if there is no reasonable expectation of my recovery from physical or mental disability, I request I be allowed to die." Now, does that mean since after all, a stiff knee is a physical disability, that I should let you die?

My point is that it is difficult to imagine how a "living will" might be written so that it would cover rationally those circumstances which raise when this kind of decision must be made.

Senator Fong. If the physician has never said-and there are legendary occasions in which physicians have been wrong-

Dr. Foye. Many. At least as many as there are physicians.

Senator Fong. Applying that principle, then the physician should never follow the "living will."

Dr. Foye. I am not sure what the "will" does for the critical situation. In other words, the concept of the "right to die" or the right to determine your own death, in a sense, implies duties. "Rights" imply "duties." I question that one can legally make it my duty or the duty of a loved one to kill a patient or to do those things that would fall in this category-withhold proper care or withhold optimum care.

I certainly would have no intention of engaging in active or passive euthanasia on the basis of a "living will,".

Senator Fong. In other words, you

would let nature take its course rather than hasten death?

Dr. Foye. I would try to do all those things that I consider best for that patient, controlling his discomfort and making his last hours, if they are his last, as comfortable as possible. That is the whole purpose of the medical profession.

Senator Fong. And that adage that a man is never too young to die nor too old to live, still should be a good adage?

Dr. Foye. Yes.

Senator Fong. Because we just can't tell when death is coming. We are never certain.

Dr. Foye. No, all treatment at best only prolongs life, even curative therapy.

Senator Percy. I would only like to comment, Mr. Chairman, that yesterday and

the day before in Chicago, Mrs.Percy and I continued our practice of many months of visiting at least two or three nursing homes on a weekend.

Yesterday, I was at the 4600 South, in one of the most hopeless nursing homes I have seen. There were 54 patients who seemed to be in the most hopeless condition. A number of them were deeply disturbed mentally but had been moved from mental institutions into the nursing home. When I left, I must say, both my wife and I were somewhat depressed. I asked Susan Atkins, the nurse who took us around, "Do you get discouraged?" And she said, "No, really, not at all. It is amazing what a little love and kindness and affection means to some of these people, how quickly they respond to it, and how it affects them more than even the medicine we give to them." So the

human spirit is a very difficult thing to destroy.

As I recall, Dr. Foye, you said that you don´t recall in your experience any patient who did not want all of the treatment that could be given in order to prolong his life, regardless of how hopeless his case might be. Is this a point of disagreement between the two of you?

Dr.Foye. I think the major concern I have is that the patient´s decisions be informed decisions.

The average patient does not know a lot about the different pathways a disease may follow.

Many doctors, including myself, argue that patients should be told if they have cancer, and others say, "Oh, this would be terribly cruel."

There have been studies on this

question and it has been found that a large percentage of cancer patients know they have cancer even if they have never been told. There are very few diseases in this world where the patient has a lump taken off and is not told what it is: that sequence tells him what disease he has. Then there is something that is tritely and famously known as the conspiracy of silence.

The doctor comes in the room and does not tell the patient what he has found. If the patient starts to ask, the doctor quickly says, "My it is a nice day outside. Do you think it might rain?", thereby informing the patient he is not to ask about his diagnosis. From that point on, the patient cannot discuss the disease with which he is dying. He is treated as if he did not understand anything about what was going on.

When you tell a patient he has cancer, however, you have to explain it to him. You have to explain to him that the majority of patients with incurable cancer do not have severe pain, and of those that do have pain, the majority can be controlled with aspirin. Of those that cannot be controlled with aspirin, all can be controlled by other medications, so that there is no such thing as having to die with excruciating pain. You have to explain to the patient that there are things you can do for him, there are medicines that will control the disease in a certain percentage of patients, and would he like to try them? When the treatment is dangerous or risky, we explain what we will do to try to avoid the dangers and risks. You have to inform the patient thoroughly so he can make the necessary decisions.

It takes a lot of time, a lot of understanding on the part of the physician about the disease, cancer, and it takes his willingness to go into the sometimes complicated forms of treatment that offer a certain percentage of responses.

I have been asked to see patients where the doctor says the patient does not know what he has. Yet when you walk in the room, the wife says, "I would like to talk to you in the hall, Doctor, he does not know what he has." I then say, "How many diseases do you ask to talk to the doctor in the hall about? What do you think he thinks he has?

Of course, the patient knows he has something terribly serious and he is just scaring himself to death with ignorance. I have yet to have a patient who was unable to handle the knowledge in an

emotionally stable way.

Is there any final comment that you would like to make?

Dr. Foye. I think Judge Cardozo said something very pertinent to this question: that there is no law of human jettison. I think that the responsibility of the physician to his patient is that he do everything he can for that patient's welfare, for that patient's comfort, for that patient's life, and when death defeats him, so be it. But I don't believe he should give the game away by default. I think death should be the failure point, not the goal.

CONCLUSION

The Court should not reverse.

Respectfully submitted,

ROBERT L SASSONE, Attorney for Amicus

NO 88-1503
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,
v.
DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,
v.
THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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Subscribed and sworn to before me on
October 11, 1989,

Lawrence D Sassone, Notary Public